Melanie Coughlin, MA
Licensed Marriage & Family Therapist, MFC35003
23421 South Pointe Dr., Suite 130
Laguna Hills, CA 92653
Tel (949) 249-4544 • Fax (949) 916-6218

Welcome!

Thank you for contacting me regarding your child or adolescent.

Please take a few minutes before your appointment at _____ to complete and read this registration packet. It includes:

1. Cover Page for general personal information
2. Informed Consent (2 pgs.) to give you important information about therapy, office policies, etc. – Read, initial and sign
3. Authorization to Treat a Minor (1 pg.) -- Read and sign
4. Permission to e-mail and/or text – Read and sign
5. Social Media Policy – Read and sign
6. No Subpoena Agreement – Read and Sign
7. Copies of Forms –Keep for your Records

Help yourself to water or tea near the door. There are restroom keys on the metal shelf with the fountain. The restroom is located diagonally across the courtyard, just past the stairs.

I look forward to meeting you.

Namaste,
Melanie

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23421 South Pointe Dr., SUITE 130
LAGUNA HILLS, CA 92653
(949) 249-4544

CLIENT REGISTRATION

CLIENT (Parents**,** please complete parent information section at bottom of this page also)

CHILD'S NAME _____ Age _____

Gender M / F /_____ DOB _____

Address _____ City _____ Zip _____

Phone ( ) _____ - home ( ) _____- minor's cell
OK to leave message? Home yes / no Cell yes / no

School _____ Grade _____ Time out of school _____

Primary Doctor or Psychiatrist _____

Medications/Medical Issues: _____

Siblings living with client full-time (Names/Ages) _____

Step or Half-siblings client sees regularly (Names/Ages) _____

Others living in the home _____

Weekly Activities _____

Special Interests _____

Pet(s) _____

PARENTS or GUARDIANS

MOTHER	*FATHER*
Name _____	Name _____
Address _____	Address _____
_____	_____
Tel: _____h _____w/c OK to leave message? Home yes / no Work/Cell - yes / no	Tel: _____h _____w/c OK to leave message? Home yes / no Work/Cell - yes / no
Primary Residence of Child? Yes No	Primary Residence of Child? Yes No
Step-Parent _____	Step-Parent _____

Referred by: _____ Okay to thank? Yes / No

Melanie Coughlin MA, LMFT, MFC35003
23421 South Pointe Dr., SUITE 130 ~ LAGUNA HILLS, CA 92653 ~ 949.249.4544

CLIENT - THERAPIST AGREEMENT / INFORMED CONSENT

Please read the following carefully. If you have any questions do not hesitate to discuss them.

CONFIDENTIALITY

Your appointment and the contents shared during that time are held in confidence. This includes all file notes, personal information provided and/or data collected during treatment. No disclosures will be made without your written permission. I do not conduct therapy via email. However, there are times when it may be appropriate to exchange information via email and you should do so only with awareness of the limitations and risks inherent in electronic communication.

Please read the circumstances, below, under which I will not, or may not, keep information confidential.

Exceptions and Limits to Confidentiality:
California State Law *mandates* reporting to authorities in the following circumstances:

- Incidents that involve child, dependent adult or elder abuse; including neglect, physical, sexual abuse or unjustifiable mental suffering.
- Disclosures of intent to harm another person.

California State Law *permits* breaking confidentiality in the following circumstances:

- Incidents that involve emotional and/or psychological abuse of a dependent adult or elder.
- Indications of client being a danger to self, others or property.

APPOINTMENTS ~ AVAILABILITY ~ THERAPY PROCESS

The length of a standard session is 45 minutes. Arrangements can be made for longer sessions for family and/or conjoint appointments, or when appropriate for individual clients. Fees and the length of these sessions will be discussed prior to scheduling any special appointments.

A telephone voice mail system (949-249-4544) is available 24 hours for messages and I normally return calls the same day. When I am not available (i.e., vacations), my message will provide the name/telephone number of an on-call therapist. **My cell phone and email will NOT contain this information. Be sure to call my work number for current availability if you are trying to reach me, as I may not have access to cell (messages/texts) or email if I am on vacation.** If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room.

The client-therapist relationship is a collaborative working partnership established and maintained by mutual trust and respect. As your therapist, I commit to provide you professional services within my scope of practice and competence. If, at any time, I determine that another professional might better serve you, I will make appropriate referrals and/or resources available to you. It is my intention to provide services that will assist you in reaching your goals. Based on the information you provide and the specifics of your situation, I will give you feedback and provide recommendations regarding your treatment. You have the right to agree or disagree and are responsible for making your own decisions. The therapy process involves certain risks and benefits. Due to the varying nature and severity of problems and the individuality of each client, it is not possible to predict or guarantee a specific outcome or result of therapy.

Melanie Coughlin, LMFT is an independent, sole-proprietor and provides services only through her own private practice. Although she shares office space with others at 23421 South Pointe Drive, Suite130, Laguna Hills, no one else is legally connected to, or responsible for, the work of Melanie Coughlin.

Initial _____

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CANCELLATIONS / RESCHEDULING

I appreciate as much notice as possible when you need to cancel or reschedule an appointment. *Appointments must be cancelled 24 hours in advance in order to avoid charges*. It is understood that emergencies arise. If something unexpected does arise, please phone as soon as possible so that we can reschedule your appointment.

_____ Initial

FEES / PAYMENT

As the client, you are fully responsible for payment of all services rendered. Payment is due at each session unless other arrangements have been made. Payment for missed/cancelled sessions (when less than 24 hours notice given) can be mailed or brought to the next appointment if less than one week away. The fee for service will remain constant unless notified of a change 30 days prior to the change.

Insurance
Please Note: I do not bill insurance directly, but will be happy to provide you with a monthly statement of services ("superbill") for you to submit to your insurance company. Payment is due at the time of service and your insurance company will reimburse you according to your policy.

FEES FOR SERVICES RENDERED**: Please remember that cancellations must be made at least 24 hours in advance to avoid being charged for the missed appointment.** Please make payment at the beginning of your session **(cash or check, payable to Melanie Coughlin).** Additional fees will be charged for telephone counseling in excess of 10 minutes, letters, reports and legal-related matters.

_____ **Initial**

Type of Session	**Fee**
Initial Intake Appointment (60 min.)	$225.
Standard Individual, Couple, Family Session (45 min)	$190.
Between session telephone counseling/contact (No charge for calls 10 min. or less)	$50. per each 15 min.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent voluntarily to receiving services based on this understanding.

SIGNATURES:

Client _____ Date: _____

Spouse or Partner _____ Date: _____

Parent/Guardian _____ Date: _____

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PARENTAL CONSENT TO TREAT A MINOR

Please read the following carefully. If you have any questions do not hesitate to discuss them.

CONFIDENTIALITY

Minor's Right to Confidentiality

Children and adolescents (under 18 years) have the same legal right to confidentiality as adults. As the parent, I understand that my child's appointment and the contents shared during that time are held in confidence. This includes all file notes, personal information provided and/or data collected during treatment. NO disclosures will be made without written permission. As your child's therapist, I appreciate the importance of parents' concern and involvement. During the first session, we will discuss the kinds of information that will and will not be kept confidential.

Exceptions and Limits to Confidentiality:
California State Law *mandates* reporting to authorities in the following circumstances:

- Incidents that involve child, dependent adult or elder abuse; including neglect, physical or sexual abuse.
- Disclosures of intent to harm another person.

California State Law *permits* breaking confidentiality in the following circumstances:

- Incidents that involve emotional and/or psychological abuse of a child, dependent adult or elder.
- Indications of client being a danger to self, others or property.

PAYMENT

Payment for services provided to a minor is considered the responsibility of the parent(s) that has requested treatment. If you and your child's other parent are sharing the cost of treatment, please make arrangements to fulfill that agreement prior to the appointment. The full fee is due at the time of each session and should be paid by the parent who accompanies the child, unless other arrangements have been made.

IF YOU ARE SEPARATED OR DIVORCED FROM YOUR CHILD'S OTHER PARENT:

1) Do you have?
   Legal Custody: ___ Joint ___ Sole (Parent: _____)
   Physical Custody: ___ Joint ___ Sole (Parent: _____)

2) Is there a court document (legal agreement) that requires the consent of both parents for mental health services? ___ Yes ___ No

3) Can you provide me with a copy of the document? ___ Yes ___ No

NAME OF MINOR _____

SIGNATURES:
Child or Adolescent's Signature: _____ Date: _____

Mother's Signature _____ Date: _____

Father's Signature _____ Date: _____

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Social Media Policy

I. My professional use of social media is limited to Twitter and LinkedIn.
I do not use Facebook, Instagram, or most other social media platforms for professional purposes.

While I value the opportunities for information and connection that social media provides, I also want to ensure your privacy and confidentiality to the degree possible. **Therefore, I do not accept "friend" requests or similar connection requests from clients.** Commenting or direct messaging through social media is not an appropriate way to contact me, and I will not respond to communication attempts through these channels. I apologize if this may at first appear to be cold; it is designed to protect your interests and your privacy. To reach me, please call 949-249-4544.

You still may find that these platforms present some risk to your confidentiality. They are known to match people using descriptions like "People You May Know" simply if you and the other person share the same contact in your phone, and have given the social media site access to your contacts. As such, you may be suggested as a potential contact for other clients, and other clients may be suggested as a potential contact for you. **I do not provide client contact information to any social media platforms, and I have no ability to control or alter how they use information about you or me that I did not share.**

II. Reducing risk to your confidentiality

As noted above, many social media platforms use data from users' phones to connect you with possible contacts. This poses some risk to your privacy and confidentiality, regardless of the fact that I do not share client information with these platforms. You can minimize that risk by:
(1) not adding me as a contact in your phone (bearing in mind your phone may create a contact automatically if you call my office from your phone), and (2) turning off any social media platform's ability to access your contacts or your location. The ultimate choice and responsibility for protecting your confidentiality relative to social media lies with you.

III. Reviewing your (or your child's) social media

I will not access your (or your child's) social media posts without your expressed permission to do so, *even if they are publicly accessible*. If you believe it will be helpful to the therapy process for me to review social media posts in session, I ask that you print them out in advance of session and bring them with you.

IV. Consultation on social media

I am a member of some closed groups on social media that are limited to other qualified mental health professionals. I may consult on your case within these groups, without revealing identifying information about you, for the purposes of providing the highest quality care.

_____ _____

Client Signature ***Date***

_____

Printed Name

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Permission to Utilize Email and Text Messaging

mcoughlin@cox.net
Cell Phone/Text: 949-468-7688

I offer an email address and text messaging as another means to contact me, in addition to voice mail. They are available for scheduling, canceling and rescheduling appointments as well as brief informational exchanges.

Be advised that communication from your personal home, office or laptop computer may not be fully confidential. I am not in control of who else may have access to your computer account(s). Both my laptop and cell phone are password protected, reasonably private and not readily accessible to anyone else. This is not a complete assurance of confidentiality, as special firewalls have not been implemented.

You will need to make the determination of whether or not you are comfortable communicating with me in this manner. I do not have lengthy conversations of a clinical nature via email or text.

Under no circumstances is email or text messaging intended to imply a more speedy access to clinical intervention during a crisis. When I am on vacation, or otherwise unavailable, my business number (949-249-4544) will provide contact information for the therapist on call during my absence.

If you are interested in providing me with your own email address for logistical communication, please write it below. Your written signature grants your permission for me to interact with you through this email account and/or via text. Email and text interactions will be primarily for the purpose of clarifying appointments and brief informational updates. Your signature indicates a clear understanding of risks and limitations of confidentiality for this method of communication.

____ I consent to communication via email, as outlined above.
____ I consent to communication via text messaging, as outlined above.
____ I extend this permission to my minor child: _____

Email address: ***@***

_____ _____
Client (or parent) Signature ***Date***

_____
Printed Name

The following 6 pages are COPIES
of
Informed Consent & No Subpoena Agreement
to keep for your records.

If you have questions at any time,
please don’t hesitate to ask me.

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Mother's Signature _____ Date: _____

Father's Signature _____ Date: _____

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_____ _____

Client Signature ***Date***

_____

Printed Name

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23421 South Pointe Dr., SUITE 130 ~ LAGUNA HILLS, CA 92653 ~ 949.249.4544

NO SUBPOENA AGREEMENT

Due to the nature of the therapeutic process and the fact it often involves disclosing information with regard to many matters which may be of a personal and confidential nature, I agree that neither I nor my attorney nor anyone else acting on my behalf will call on Melanie Coughlin, MA, LMFT:

- To become a witness to testify in court, at depositions or any other legal proceeding
- To disclose client psychotherapy records
- To communicate with child custody evaluator/s or other representatives of the court

I understand the reason for this agreement is that the purpose and interests of the courts may not be in the best interests of, and may interfere with, my own therapeutic work.

_____
Name (print)

_____
Signature

_____
Date

THIS IS YOUR COPY